Medical History

Patient Name:_____ **Date of Birth:** _____

Medical History:

List all medical conditions for which you are being treated (include anything you are currently taking medications to treat)

☐ **High Cholesterol** ☐ **Cancer** ☐ **Thyroid Disorder** ☐ **Seasonal Allergies** ☐ **Migraines**

☐ **High Blood Pressure** ☐ **Diabetes** ☐ **Depression** ☐ **Fibromyalgia** ☐ **Lupus**

☐ **Sjogren's** ☐ **Gout** ☐ **Rheumatoid Arthritis** ☐ **Psoriatic Arthritis** ☐ **Ankylosing Spondylitis**

☐ **Osteoarthritis** ☐ **Osteoporosis** ☐ **Giant Cell Arteritis** ☐ **Other -See Attached List**

_____

_____

Do you use tobacco?	☐ Yes	☐ No	
Do you use alcohol?	☐ Yes	☐ No	
Flu Vaccination?	☐ Yes	☐ No	If Yes; Date: _____
Covid-19?	☐ Yes	☐ No	If Yes; Date: _____
Pneumococcal Vaccination?	☐ Yes	☐ No	If Yes; Date: _____
Shingles Vaccination?	☐ Yes	☐ No	If Yes; Date:

Surgical History:

Please provide detailed summary including dates:

_____

_____

_____

_____

_____

Current Medications:

Please include any prescriptions, over the counter drugs, and vitamins/supplements.

☐ **See Attached List** ☐ **Not currently taking any medications**

Drug Name	Dosage	Frequency (at bed time, 2x a day, etc.)	Route (Oral, sublingual, injection, spray)

Allergies: ☐ See Attached List ☐ No Known Drug Allergies

List all medications that you are allergic to:

Drug Name	Reaction (rash, hives, etc.)

Patient Signature (Guardian if applicable) **Date**

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